1st 52 WEEK PERIOD

RETURN TO WORK PLAN TIME ENCUMBRANCE

Department of Labor and Industries

This form must be filled out by a Vocational Rehabilitation Counselor who has received a referral from the State Fund.

☐ **Original** ☐ **Modification**

		Date of this request	Claim number
Vocational counselor or Intern	VRC or Intern ID #		
Vocational counseling firm's name	Phone number	Injured worker's name	Date of injury
Address	Provider # & branch	Home address	Phone number
City/State	ZIP	City/State	ZIP

Type of Request:

- ☐ ORIGINAL
- ☐ MODIFICATION
  - ☐ Change in costs
  - ☐ Change in time frames
  - ☐ Change in goal
  - ☐ Change in training site
  - ☐ Other (specify) _____
- ☐ Revision of disapproved plan

Plan Dates Requested

- ☐ Effective start date, 1st 52 weeks _____
- ☐ Change start date to _____
- ☐ Interrupt plan on _____
- ☐ Restart plan on _____
- ☐ Continue time loss to _____
- ☐ LEP to start on _____
- ☐ LEP to end on _____
- ☐ End date, 1st 52 weeks _____
- ☐ Early plan termination _____

Goal	DOT		Census
Method	Training site	Contact person	Phone
Date signed	VRC or intern ID#	Signature, VRC or intern X	

L&I USE ONLY _____

For Dept Use Only

Claims Manager ☐ Approved ☐ Disapproved	Date signed	Phone No.	Signature